



DENTAL BOARD OF CALIFORNIA
 1432 HOWE AVENUE, SUITE 85, SACRAMENTO, CA 95825-3241
 TELEPHONE: (916) 263-2300 FAX: (916) 263-2140
www.dbc.ca.gov



Request for Certification of California Dental License

Non-Refundable Fee: \$2.00

Enclose personal check or money order

For Office Use Only

Receipt _____ RC _____

Date _____ \$ _____

Mailed date _____

Name (first, middle, last) _____

Telephone number _____ License number _____

Address to which you wish the certification sent:

DECLARATION *I authorize the Dental Board of California to send a certification of my California dental license to the address above.*

Signature _____ Date _____

Complete this section only if exam scores are **required**.

DECLARATION *I authorize the Dental Board of California to disclose the scores from my California dental license examination to the address above within 60 days of the date of my signature.*

Signature _____ Date _____

INFORMATION COLLECTION AND ACCESS

The information requested herein is mandatory and is maintained by Dental Board of California, 1432 Howe Ave, Suite 85, Sacramento, CA 95825, Executive Officer Cynthia Gatlin, 916-263-2300, in accordance with Business & Professions Code, §1600 et seq. Failure to provide all or any part of the requested information will result in the rejection of the request as incomplete. Each individual has the right to review the personal information maintained by the agency unless the records are exempt from disclosure.